

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

00873

2910

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:  
County..... Talbot County  
City or town..... St. Michaels.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... All his life.  
Hospital, institution, or street address where death occurred:  
St. Michaels, Maryland.  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland County..... Talbot  
City or town..... St. Michaels  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

3. (a) FULL NAME  
Frisby Bailey

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	widowed

6.(b) Name of husband or wife..... Annie Bailey.

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... December 10, 1855.

8. AGE: Years Months Days If less than one day  
91 1 16 hrs. min.

9. Birthplace..... Talbot County, Maryland.  
(Town, county, and state)

10. Usual occupation..... Laborer.

11. Industry or business.....

MOTHER FATHER 12. Name..... William Bailey.

13. Birthplace..... Talbot County, Maryland.

14. Maiden name..... Louise Johnson.

15. Birthplace..... Talbot County, Maryland.

16. Informant..... Annie Miller.

Address..... Rolles Ranges, St. Michaels.

17. Burial..... Date thereof..... Jan. 29 "47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... St. Michaels,

Location..... St. Michaels, Maryland.

18. Funeral director..... J. Norman Marshall.

Address..... St. Michaels, Maryland.

19. Jan 29 1947 *John W. Marshall*  
(Date rec'd by registrar) *Registrar*

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan 26, 1947 19..... 12<sup>th</sup> noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Jan. 26, 1947 19..... to Jan 26, 1947 19.....

and that I last saw him alive on 2 wks 19.....

Immediate cause of death..... Uremia Acute

Due to..... Arteriosclerotic Nephritis

Due to.....

Other conditions..... Generalized Arterio-  
sclerosis, Senility, Hypertension  
(Include pregnancy within 3 months of death)

Major findings of operations..... None

Date of op. .... None

Autopsy results..... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide.....

Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

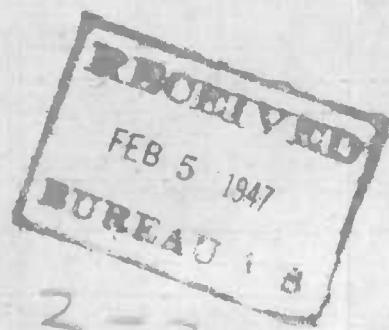
Injured at work?

23. SIGNATURE..... *P. B. Sheppard*

M. D. or other

Address..... St. Michaels, Md

Date signed..... 1.27.47



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00874

56a

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

8 days

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

8 days

## 3. (a) FULL NAME

Mary Elizabeth Baynard

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

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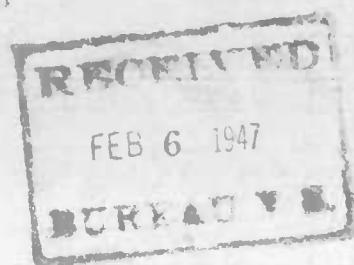
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2-35

12 *free*  
 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00875

## CERTIFICATE OF DEATH

Reg. Dlat. No. 2900

## 1. PLACE OF DEATH:

County

Talbot

City or town

Easton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

1 day

Hospital, institution, or street, address where death occurred

Memorial Hospital

How long in hospital or institution?

1 day

## 3. (a) FULL NAME

Barney Brooks

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m

b

Widowed

B. (b) Name of husband or wife

Emma Nixon

Brooks

B. (c) If alive, give age years

March 25, 1880

7. Birth date of deceased (mo., day, yr.)

deceased

(mo., day, yr.)

March 25, 1880

8. AGE:

Years

Months

Days

If less than one day

66

10

20

hrs.

min.

9. Birthplace

Easton

Md

(Town, county, and state)

10. Usual occupation

Cook

11. Industry or business

Private home

John Brooks

12. Name

John Brooks

13. Birthplace

Talbot Co. Md

14. Maiden name

Mary A. Summers

15. Birthplace

Talbot Co. Md

16. Informant

Bertha Brooks

Address

Easton

Md

Buried

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Reedlands

Location

Easton

Md

17. Funeral director

John T. Brooks

Address

310 South St.

Easton

Md

18. Funeral director

John T. Brooks

Address

310 South St.

Easton

Md

19. (Date rec'd by registrar)

1/21

1947

(Date rec'd by registrar)

R. H. Reeves

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland county

Talbot

City or town

Easton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

January 20, 1947, at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 15, 1947, to Jan 20, 1947

and that I last saw him alive on Jan 15, 1947

Immediate cause of death

Pneumonia tubercular

5 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

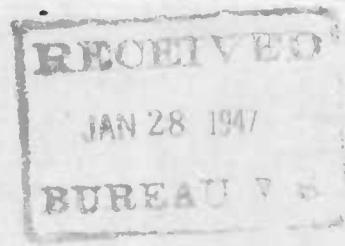
Martin Z. Russell, M.D.

M. D. or other

Address

Porto, Md

Date signed



2-35

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

00876

## CERTIFICATE OF DEATH

Reg. Dist. No. 2900

## 1. PLACE OF DEATH:

County

Talbot

City or town

Easton Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

60 days

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

66 days

## 3. (a) FULL NAME

EMMETT

James Burns

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Hannah Davis Burns

7. Birth date of deceased (mo., day, yr.)

Oct 16 - 1880

6. (c) If alive, give age

68

years

8. AGE:

Years Months Days If less than one day

66 3 0 hrs. min.

9. Birthplace

Perry Corners Gaithersburg Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

Thomas Burns

Talbot Co Maryland

MOTHER

Mary Clark

Dorset New

16. Informant

Everett Burns

Address

Georgetown Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Jan 18 - 47

Cemetery or crematory

Chesterfield

Location

Centreville Maryland

18. Funeral director

Bartow Bros

Address

Centreville Maryland

19. (Date rec'd by registrar)

1/12 1947

N.H. Neerius

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Queen Anne

City or town

Georgetown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH

January 16 1947 at 6:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11 Nov 1946 to 16 Jan 1947

and that I last saw him alive on 16 Jan 1947

Immediate cause of death

Arteriosclerosis Heart Disease

DURATION

years

Due to

Hypertension Atrial fibrillation

Thrombosis 2.100601sm

Other conditions Auto accident, Frost

Skull Amputation H. 109

(Include pregnancy within 3 months of death)

Major findings of operations Corp. laryngeal tracheal

ligation 1/19

Date of op. 12 Nov 46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of

Where did injury occur? (City or town) (County) (State)

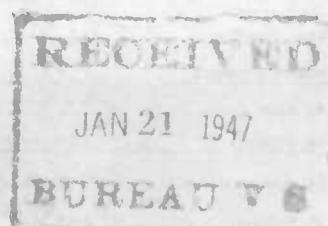
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. T. Kinnaman, MD

M. D. or other

Address Easton, Md. Date signed 17/01/47



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4800

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

00877

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Margaret Fairinger Cawthon.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F. W. Married

## 6. (b) Name of husband or wife

Alton A. Cawthon.

## 7. Birth date of deceased (mo., day, yr.)

October 20, 1897

## 8. AGE:

Years	Months	Days	If less than one day
49	2	18	hrs. min.

## 9. Birthplace

Tulsa, Okla. (Town, county, and state)

## 10. Usual occupation

Housewife.

## 11. Industry or business

FATHER

George W. Fairinger

## 13. Birthplace

Md.

## 14. Maiden name

Sarah K. Cawthon.

## 15. Birthplace

Md.

## 16. Informant

W. J. Fairinger.

## Address

Easton, Md.

## Burial

Date thereof Jan 14, 1947

## (Burial, cremation, or removal, which)

Cemetery or crematory St. Joseph.

## Location

Easton, Md.

## 18. Funeral director

Blanchard.

## Address

Easton, Md.

## 19. (Date rec'd by registrar)

1/16/47

D. St. Neury

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot.

City or town Easton (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

January 8 1947 at home

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-6-1947 to 1-8-1947

and that I last saw her alive on 1-6-1947

## Immediate cause of death

Carcinoma of uterus.

## DURATION

6 months

## Due to

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of injury

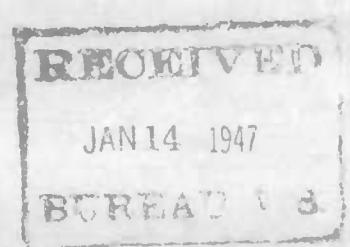
## Injured at work?

## 23. SIGNATURE

P. C. Cawthon

M. D. or other

Address Easton, Md. Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

Dr. Harrison

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00678

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County

1746 lot  
EASTON, MD. RURAL.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

HARRY PAUL CECIL

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MALE W

B. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) May 18, 1946

6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day

7 mo. 7 23 hrs. min.

9. Birthplace EASTON, 1746 lot, Md.

(Town, county, and state)

10. Usual occupation

## 11. Industry or business

EDGAR CECIL

12. Name EDGAR CECIL

13. Birthplace Queen Anne Co. Annapolis

14. Maiden name EVELYN LELLIS

15. Birthplace Stevensville, Md. Queen Anne

16. Informant Edgar Cecil

Address Easton, Md. P. O. O.

17. Burial Date thereof Jan 13/47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Stevensville

Location Stevensville, Md.

18. Funeral Director

Address Easton, Md.

19. (Date rec'd by registrar) 1/11 1947

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County Talbot

City or town EASTON, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH 10 Jan 47 19 1900 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10 Jan 1947 to 10 Jan 1947

and that I last saw h. alive on 19 1947

Immediate cause of death

Heart case

Due to gross parental neglect - nothing else

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

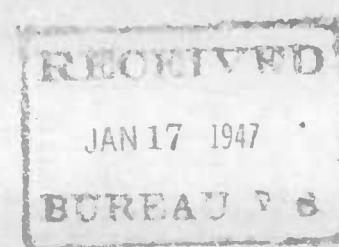
Injured at work?

23. SIGNATURE

Dr. Harrison M.D.

M. D. or other

Address 214 E. Penn St. Caton Date signed 1/11/47



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00879

## CERTIFICATE OF DEATH

Reg. Dist. No. 2900

## 1. PLACE OF DEATH:

County TalbotCity or town Easton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 hours

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 12 hours

## 3. (a) FULL NAME

Betty Roberta Lee Chase

4. Sex

F

5. Color or race

BB Single

6. (a) Single, married, widowed, or divorced

B. (b) Name of husband or wife

James 16th - 47

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 4 Months 0 Days 1 If less than one day  
hrs. 40 min. 40

9. Birthplace

(Town, county, and state) Trappe, Md.

10. Usual occupation

Infant

11. Industry or business

12. Name Tosiah Chase13. Birthplace Trappe, Md.14. Maiden name Mary Scott15. Birthplace Trappe, Md.

16. Informant

Memorial Hospital

Address

Easton, Maryland

17. (Burial, cremation, or removal, Which?)

Burial Date thereof Jan. 20-1947  
(month) (day) (year)

Cemetery or crematory

Trappe

Location

Trappe, Maryland

18. Funeral director

Joseph Chase

Address

Trappe, Md.

19. (Date rec'd by registrar)

1/201947D. H. Nease

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Trappe (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 20 1947, a.m. 6 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 19, 1947, to Jan. 20, 1947, and that I last saw her alive on Jan. 19, 1947.Immediate cause of death Delivery stillborn Atelactensis

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

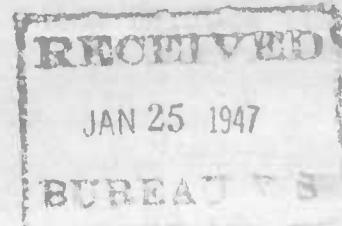
Injured at work?

23. SIGNATURE

H. S. Seymore

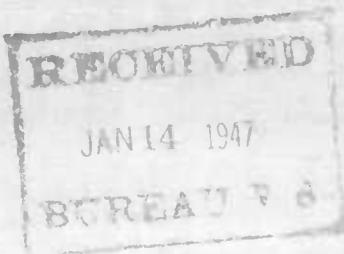
M. D. or other

Address Trappe, Md. Date signed 1-20-47



1-35





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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

## CERTIFICATE OF DEATH

Reg. Dist. No.

00881-2910

## 1. PLACE OF DEATH:

County..... Talbot County  
 City or town..... St. Michaels  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Linder Cooper

4. Sex      5. Color or race      6. (a) Single, married, widowed, or divorced

Male      Colored      Married

8. (b) Name of husband or wife..... Hattie Cooper

7. Birth date of deceased (mo., day, yr.)      6. (c) If alive, give age..... years

June 22, 1909.

8. AGE:      Years      Months      Days      If less than one day  
 37      6      22      hrs.      min.9. Birthplace..... Luningberg, Virginia  
 (Town, county, and state)

10. Usual occupation..... Laborer

## 11. Industry or business

12. Name..... Unknown

13. Birthplace..... Unknown

14. Maiden name..... Unknown

15. Birthplace..... Unknown

16. Informant..... Hattie Cooper

Address      St. Michaels, Maryland.

17. Burial..... Date thereof.... Jan. 15, 1947  
 (Burial, cremation, or removal. Which?)      (month) (day) (year)

Cemetery or crematory..... Sherwood Cemetery

Location..... Sherwood, Maryland.

18. Funeral director..... J. Norman Marshall.

Address      St. Michaels, Maryland.

19. Jan 15-47 John Howard  
 (Date rec'd by registrar)      Local      Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland      County..... Talbot

City or town..... St. Michaels  
 (If outside city or town limits, write RURAL and give nearest town)Street No.....  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

220-12-1868

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 13 January 1947, at 2<sup>00</sup> A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 2 August 1946, to 13 January 1947,  
 and that I last saw her alive on 29 December 1946.  
 Immediate cause of death..... Heart Failure

DURATION

Due to..... Cardio-renal disease  
 with lymphatic obstruction      2 years

Due to.....

Other conditions..... Anasarca

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)      (County)      (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Dr. Herbert Morrison  
 M. D. or other

Address..... St. Michaels, Md. Date signed..... 15 Jan. 47

Feb 5 1947

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of age is shown on

G 108 2/10/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46b

Reg. Dist. No. 2910

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Talbot

Newcomb

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Fritz Facklum

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Fannie Facklum

6. (c) If alive, give age

65

years

7. Birth date of deceased (mo., day, yr.)

June 22, 1869.

8. AGE:

Years

Months

Days

If less than one day

77

7/8

6

16

hrs. min.

9. Birthplace

Copenhagen, Denmark

(Town, county, and state)

10. Usual occupation

Mechanic

11. Industry or business

FATHER

12. Name

William Facklum

MOTHER

13. Birthplace

Denmark

MOTHER

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Fannie Facklum

Address

Newcomb, Maryland

17. Burial

Date thereof Jan. 9, 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

St. Michaels Cemetery

Location

St. Michaels, Maryland

18. Funeral director

J. Norman Marshall

Address

St. Michaels, Maryland

19. Date rec'd by registrar

Jan. 8, 1947 John L. Howard

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Talbot

City or town St. Michaels, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

7 January 1947, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

23 December 1946, to 7 January 1947,

and that I last saw him alive on 6 January 1947.

Immediate cause of death

Carcinoma of stomach with metastasis to abdominal organs

DURATION

Due to

viruses

Due to

—

Other conditions

—

(Include pregnancy within 3 months of death)

Major findings of operations

Carcinoma of stomach with metastasis to abdominal organs

Date of op.

—

Autopsy results

—

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

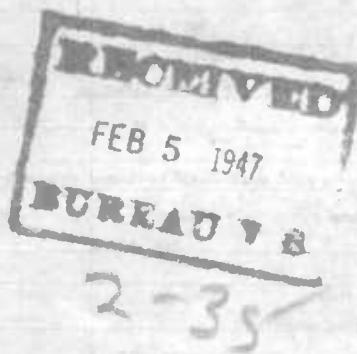
23. SIGNATURE

Dr. Perkins M.D.

M. D. or other

Address Royal Oak, Md.

Date signed 1/7/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. White

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1572

00883

## CERTIFICATE OF DEATH

Reg. Dist. No. 2900

## 1. PLACE OF DEATH:

County.....

Talbot

City or town.....

Cordova

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

14 days

Hospital, institution, or street address where death occurred:

Maryland Hospital

How long in hospital or institution?

14 days

## 3. (a) FULL NAME

Patricia Jane Flaherty

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.) Dec. 21-46

8. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

17

hrs.

min.

9. Birthplace.....

Cordova, Md.

(Town, county, and state)

10. Usual occupation.....

none

11. Industry or business

12. Name.....

Mrs Harry Flaherty

Caroline Co.

13. Birthplace

14. Maiden name.....

Mary Sharp

Luben Anne Co.

15. Birthplace

16. Informant.....

Harry Flaherty

Cordova, Md.

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Concord

Location.....

18. Funeral director.....

Concord, Maryland

Virgil Woods, Jr.

Address

Denton, Md.

19. (Date rec'd by registrar)

19.46

D. St. Neary

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland County.....

Talbot

City or town.....

Cordova (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH.....

Jan. 3

1946, at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 21, 1946, to Jan. 3, 1947

and that I last saw her alive on Jan. 3, 1947

Immediate cause of death.....

Myocardial Dystrophy

DURATION

12 hrs

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

None

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

George A. White, M.D.

M. D. or other

Address.....

Date signed.....

RECEIVED

JAN 11 1947

BUREAU 73

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and completely. Physicians: please write the causes of death clearly and briefly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-2

## CERTIFICATE OF DEATH

00884

754

Reg. Dist. No.

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Julie Ann Lubert

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F.

W.

Widowed

## 6. (b) Name of husband or wife

Gains A. Lubert

7. Birth date of

deceased (mo., day, yr.)

5-10-1853

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

93

7

26

hrs.

min.

9. Birthplace

Chestertown, Talbot Co. Md.

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

own home

FATHER

12. Name

F. G. Lubert

13. Birthplace

Talbot Co. Md.

14. Maiden name

Sarah A. Howell

15. Birthplace

Talbot Co. Md.

16. Informant

Joseph A. Lubert

Chestertown, Md.

Address

Burial

Date thereof

1-8-47

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

St. John's

Location

Chestertown, Md.

16. Funeral director

J. Norman Marshall

Address

St. Michaels, Md.

17. 1-8-47

19

(Date rec'd by registrar)

18. Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Jan 6 1947 at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1946 to Jan 6 1947

and that I last saw her alive on Jan 5 1947

Immediate cause of death

Abdominal Tumor

Malignant - middle and upper abdomen

Due to: Carcinoma of intestines

DURATION

6 mo

Due to

Other conditions due to advanced age and feebleness

no known were taken

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED

JAN 30 1947

BUREAU

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00885

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County

Talbot

City or town

Eastern Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Eighteen days

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital, institution?

Eighteen days

## 3. (a) FULL NAME

Baby Girl Higgins

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

S

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Dec. 31, 1946

6. (c) If alive, give age years

15

Years

Months

Days

15 hrs. min.

9. Birthplace

Memorial Hospital - Easton, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

Harold Higgins

FATHER

13. Birthplace

14. Maiden name

Ruth Kalota

15. Birthplace

16. Informant

Memorial Hospital

Address

Easton, Md.

17. (Burial, cremation, or removal, which?)

Burial

Date thereof

1/19/47

Date (month) (day) (year)

Cemetery or crematory

Springhill

Location

Easton, Md.

18. Funeral director

Manual Neivius Son

Address

Easton, Md.

19. (Date rec'd by registrar)

1/16/47

Date signed

1/16/47

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Caroline

City or town

Preston, Md.

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

January 16 1947 at 5:25 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1947, to Jan 16 1947

and that I last saw her alive on Jan 15 1947

Immediate cause of death Hyperthyroidism

pulmonary

DURATION 48 hrs

Due to Congenital heart failure

15 days

Other conditions Congenital heart disease type undetermined

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results unreported

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

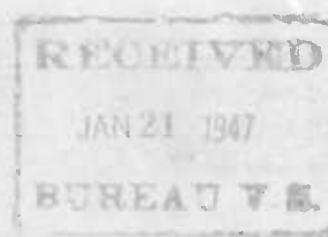
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. T. B. Ambler MD

M. D. or other

Address Easton, Md. Date signed 1/16/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00886

290

Reg. Dist. No.

## 1. PLACE OF DEATH:

County Talbot Caroline  
 City or town Greensboro Maryland Caroline  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Caroline Memorial Hospital

How long in hospital or institution?

2 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot  
 City or town Greensboro Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (b) Social Security Number

## 3. (a) FULL NAME

Robert Kennedy Jr.4. Sex Male 5. Color or race Black 6.(a) Single, married, widowed, or divorced Single6.(b) Name of husband or wife Mary Elizabeth Kennedy7. Birth date of deceased (mo., day, yr.) 6. (c) If alive, give age years 19048. AGE: Years 43 Months  Days  If less than one day hrs. min.9. Birthplace Maryland (Town, county, and state)10. Usual occupation Labrador

11. Industry or business

12. Name Emmett Kennedy13. Birthplace Maryland14. Maiden name Doris Lee Gould15. Birthplace Maryland16. Informant Emmett KennedyAddress Greensboro Rural17. Burial Burial Date thereof 1/25/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory GreensboroLocation Near Greensboro Md.18. Funeral director Raymond B. RawlingsAddress Greensboro Md.19. 1/24 1947 D.S. Deceased  
 (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 20 1947 at 10 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 1947 to January 20 1947 and that I last saw him alive on January 19 1947.Immediate cause of death Vascular ShockDue to Gren shot (bullet 38) in abd with generalizedDue to peritonitis 20 hours

Other conditions

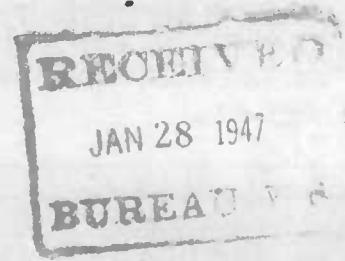
(Include pregnancy within 3 months of death)

Major findings of operations Perforation of stomach and small intestine Date of op. 1/19/47Autopsy results All perforations closed Peritonitis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Homicide Date of 1/18/47Where did injury occur? Greensboro Caroline Md. (City or town) (County) (State)Injured at home, farm, industry, public place (where?) homeMeans of injury Bullet wound Injured at work? No23. SIGNATURE D. T. B. Ambler M.D. M. D. or otherAddress 214 E. Dover St. Date signed 1/20/47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

104-a

00887

## CERTIFICATE OF DEATH

Reg. Dist. No. 291

## 1. PLACE OF DEATH:

County Talbot

City or town Royal Oak, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

William Noah Limberry

4. Sex Male 5. Color or race Black 6. (a) Single, married, widowed, or divorced

Infant

6. (b) Name of husband or wife

7. Birth date of deceased (mo. day, yr.) Jan. 17, 1947 8. (c) If alive, give age years

8. AGE: Years Months Days If less than one day  
6 hrs. min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Lloyd Washington Limberry

13. Birthplace St. Michaels Md.

14. Maiden name Mary Emma Greene

15. Birthplace Royal Oak Md.

16. Informant Mary Emma Limberry

Address Royal Oak Md.

17. Burial Date thereof Jan. 23, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cemetery Royal Oak

Location Royal Oak Talbot Co.

18. Funeral director Frank Clark Acting

Address Royal Oak Talbot County

19. Jan. 23 1947 H. W. Wales  
(Date rec'd by registrar) Local Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Talbot

City or town Royal Oak Md. (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/23 19 47, at 3 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 17th 19 47, to Jan. 22 19 47.

and that I last saw h. im. alive on Jan. 22 19 47.

Immediate cause of death cold

Bronchopneumonia

DURATION

Exposure

Due to:

Other conditions Rain dripped on baby - mother  
not intelligent enough to move baby  
(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

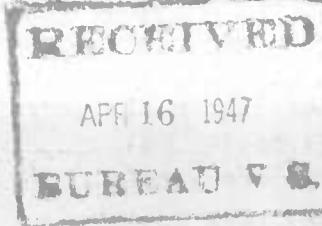
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Dr. Louis H. Hartman M.D. or other

Address Boston Rd. Date signed 4-15-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 939

00888

## CERTIFICATE OF DEATH

Reg. Dist. No. 292

1. PLACE OF DEATH: Talbot  
 County.....  
 City or town.....Talbot, Md. (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? End of life  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State.....Md. County.....Talbot  
 City or town.....Talbot, Md. (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Sarah Elizabeth Muilekin

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife John R. Muilekin

7. Birth date of deceased (mo., day, yr.) Oct. 5 1861 6.(c) If alive, give age.....years

8. AGE: Years 85 Months 3 Days 215 If less than one day  
 hrs. ..... min. ....

9. Birthplace Talbot Co., Md.  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business None

12. Name Leonard

13. Birthplace Talbot Co., Md.

14. Maiden name Sarah Ann Hosley

15. Birthplace Talbot Co., Md.

16. Informant Mrs. Sadie Cripe

Address Talbot, Md. B

17. Burial Burial Date thereof Feb. 1, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Terra Hill

Location Talbot, Md.

18. Funeral director Maurice L. Thompson, Son

Address Faxton, Md.

19. Date rec'd by registrar Jan. 31, 1947 Josephine Rose Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 30, 1947 at SA M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 1946 19..... to Jan. 30, 1947 19.....

and that I last saw her alive on Jan. 25, 1947 19.....

Immediate cause of death Chronic myocarditis DURATION 3 years

Due to.....

Due to.....

Other conditions Paroxysmal Agland 3 years

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE Josephine Rose M. D. Mother

Address Talbot, Md. Date signed Jan. 31, 1947



1-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00889

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

## 1. PLACE OF DEATH:

County Talbot and P.O. Box  
City or town Easton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Dusie Ockimay

4. Sex

female

5. Color or race

C

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Oscar Ockimay

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Nov. 12, 1870

8. AGE:

70

Years

2

Months

2

Days

1

If less than one day

hrs. min.

9. Birthplace

Easton Talbot and

(Town, county, and state)

10. Usual occupation

Labour

11. Industry or business

Religious Basin

12. Name

Richardson

13. Birthplace

England

14. Maiden name

Mary Brooks

15. Birthplace

Talbot County

16. Informant

Oscar Ockimay

17. Burial

Easton

(Burial, cremation, or removal. Which?)

Date thereof Jan. 16/47

(month) (day) (year)

Cemetery or crematory

Richardson Cemetery

Location

Easton

18. Funeral director

Richardson

Address

Easton

19. (Date rec'd by registrar)

1/14 47 N.H. Morris

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

MD County Talbot

City or town

Easton R.D. (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 14 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... to ..... 19....., to ..... 19.....

and that I last saw him ..... alive on ..... 19.....

Immediate cause of death

Acute alcoholism

DURATION

? hrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

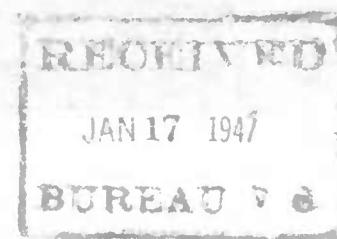
Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE Louis P. Kelly, M.D. Deplaudex M. D. or otherAddress Easton Md. Date signed 1-14-47



1-35





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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

834  
00891

## CERTIFICATE OF DEATH

Reg. Dist. No. 2720

## 1. PLACE OF DEATH:

County BaltimoreCity or town Oxford

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 8 years

## 3. (a) FULL NAME

Helen Lee Reiter

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Bradford Reiter

7. Birth date of deceased (mo., day, yr.)

Aug 26 - 1892

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years 74Months 4Days 20

If less than one day

hrs.

min.

## 9. Birthplace

Philadelphia

(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

Shoemakers, Henry Mudge

## MOTHER FATHER

Philadelphia

## 12. Name

Mary Emma Sheppard

## 13. Birthplace

Philadelphia

## 14. Maiden name

Philadelphia

## 15. Birthplace

Philadelphia

## 16. Informant

Ella M. Jackson

## Address

Rushmore Apt Pittsburgh 13 Pa

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Jan 17 - 47

(month)

(day)

(year)

## 18. Cemetery or crematory

Oxford, Pa

## Location

Oxford, Pa

## 19. Funeral director

P. J. Reiter

## Address

Carlton Rd

## 20. (Date rec'd by registrar)

Jan 16 - 1947

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MDCounty BaltimoreCity or town Oxford

Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

## 2(a) IF VETERAN, NAME WAR

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

January 14 - 1947 at 3:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1946 to January 14, 1947, end that I last saw her alive on January 13, 1947

## Immediate cause of death

Obstruction of lung

DURATION

3 days

## Due to

Emphysema4 months

## Due to

Arteriosclerosis1 1/2

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings:

Of operations

## Of autopsy

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

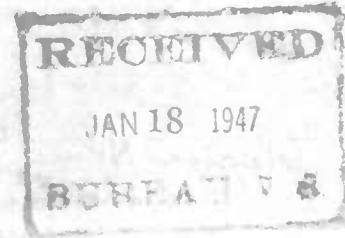
## 23. SIGNATURE

Josephine Ross

M. D. or other

Address

Grange RdDate signed Jan 16 - 1947



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

## CERTIFICATE OF DEATH

Reg. Dist. No.

5294

## 1. PLACE OF DEATH:

County

Talbot

City or town

Wye Mills

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Lizzie L. Smith

4. Sex

Female

5. Color or race

Col

6. (a) Single, married, widowed, or divorced

Widowed

B. (b) Name of husband or wife

Wm. Smith

7. Birth date of

deceased (mo., day, yr.)

3-21-1896

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

50

9

29

9. Birthplace

Talbot N.C.

(Town, county, and state)

10. Usual occupation

Packing house worker

11. Industry or business

Packing house

12. Name

Villa Kane

13. Birthplace

Talbot N.C.

14. Maiden name

Lucy Ballou

15. Birthplace

Talbot N.C.

16. Informant

Bridie Hawkins

Address

Wye Mills Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Sherwood Cem.

Location

Sherwood Md.

18. Funeral director

J. Warren Marshall

Address

St. Michaels

19. 1-23

1917

G. J. Ferguson

Registrar

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Talbot

City or town

Wye Mills

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

231-07-3995

## MEDICAL CERTIFICATION

20. DATE OF DEATH

January 20 1917 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 12 1917 to Jan 20 1917 and that I last saw her alive on Jan 2 1917

Immediate cause of death

cerebral hemorrhage 42 lbs

Due to

Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

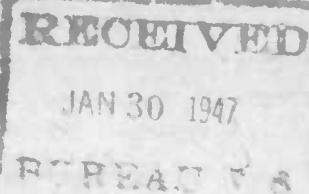
George W. Reger M.D. or other

Address

P. O. Box 10143

60892

5294



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 115c

00893

## CERTIFICATE OF DEATH

Reg. Dist. No. 20

## 1. PLACE OF DEATH

County

Talbot

City or town

Easton Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

27 hours.

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in Hospital or institution?

27 1/2 hrs.

## 3. (a) FULL NAME

Bruce Thomas

4. Sex

M

5. Color or race

B

6. (a) Single, married, widowed, or divorced

S

## 6. (b) Name of husband or wife

Sept. 26, 1945

7. Birth date of

deceased (mo., day, yr.)

Sept. 26, 1995

8. AGE:

Years

Months

Days

It less than one day

hrs.

min.

## 9. Birthplace

Bellevue, Maryland

(Town, county, and state)

## 10. Usual occupation

infant

## 11. Industry or business

Morris Thomas

12. Name

Bellevue, Md

13. Birthplace

Ettas S. White

14. Maiden name

Bellevue, Md

15. Birthplace

Morris Thomas (father)

16. Informant

Bellevue, Md

Address

Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

St. Luke's

Location

Royal Oak

18. Funeral director

John A. Williams

Address

Easton

19. (Date rec'd by registrar)

1/21/47

1947

M. D. or other

Date signed

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Talbot

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

January 21, 1947, at 6 40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 20, 1947, to Jan. 21, 1947

and that I last saw him alive on Jan. 21, 1947

## Immediate cause of death

Address, etc. to

(Left) Sudden death

7 days

Due to

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings or operations

Left

Date of op. 1/20/47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

J. J. Hoble

M. D. or other

Date signed

Registrar

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

934

## CERTIFICATE OF DEATH

Reg. Dist. No. 2920

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: Talbot Co.  
 County: Trappe  
 City or town: Trappe  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death: 50 years  
 Hospital, Institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State: MD County: Talbot  
 City or town: Trappe  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.:  
 (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

Otto Anton Thome

4. Sex: <u>Male</u>	5. Color or race: <u>white</u>	6.(a) Single, married, widowed, or divorced: <u>widower</u>
---------------------	--------------------------------	---

6.(b) Name of husband or wife: Mary Rebecca Thome7. Birth date of deceased (mo., day, yr.): Mar 21 1874

8. AGE: Years: <u>72</u>	Months: <u>9</u>	Days: <u>18</u>	It less than one day: <u>hrs. ....</u>	min. ....
--------------------------	------------------	-----------------	--	-----------

9. Birthplace: Harrisburg, Pa  
 (Town, county, and state)10. Usual occupation: Farmer11. Industry or business: Joseph Thome

12. Name: <u>Joseph Thome</u>
-------------------------------

13. Birthplace: <u>Germany</u>
--------------------------------

14. Maiden name: <u>Anna E. Rhinefeld</u>
---

15. Birthplace: <u>Germany</u>
--------------------------------

16. Informant: <u>Mrs. Palmer Stevens</u>
---

Address: <u>Trappe, Md. B</u>
-------------------------------

17. Burial, cremation, or removal, which? <u>Burial</u>	Date thereof: <u>Jan 11 1947</u>
---	----------------------------------

Cemetery or crematory: <u>Oxford</u>
--------------------------------------

Location: <u>Oxford, Md.</u>
------------------------------

18. Funeral director: <u>Macie E. Newnam</u>
--

Address: <u>Easton, Md.</u>
-----------------------------

19. Date rec'd by registrar: <u>Jan 9 1947</u>	Joseph Rogers
--	---------------

(Date rec'd by registrar)	Local Registrar
---------------------------	-----------------

3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 9, 1947, at 5:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on Jan 9 - Jan 1947Immediate cause of death: Cardiac decompensationDURATION: 30 minDue to: Observe myocarditisDue to: Observe myocarditisOther conditions: Gastric overactivityDate of op.: 7 years

(Include pregnancy within 8 months of death)

Major findings or operations.

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, Industry, public place (where?)

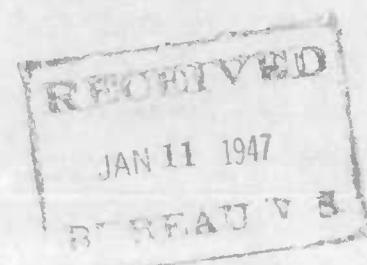
Means of injury

Injured at work?

23. SIGNATURE: Joseph Rogers

M. D. or other

Address: Trappe, Md. Date signed: Jan 9 1947



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

## CERTIFICATE OF DEATH

00895

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County, Talbot

City or town, Easton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 days

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 19 days

## 3. (a) FULL NAME

Thomas J. Todd

4. Sex

5. Color or race

Male white

6. (a) Single, married, widowed, or divorced

B. (b) Name of husband or wife

Mary A. Todd

7. Birth date of

deceased (mo., day, yr.)

Sept. 10, 1868

6. (c) If alive, give age years

8. AGE:

78 Years Months Days It less than one day

Seventy-eight 4 4 . . . . .

9. Birthplace

Dorchester Co. Md.

(Town, county, and state)

10. Usual occupation

Farmer

Retired

11. Industry or business

Elisha T. Todd

12. Name

Dorchester Co. Md.

13. Birthplace

Sallie Martha Clegg

14. Maiden name

Dorchester Co. Md.

15. Birthplace

Howard A. Todd

16. Informant

Howard A. Todd

Address

Federalsburg Md

17. Burial

(Burial, cremation, or removal, which?)

Date thereof 1/26/47

Cemetery or crematory

Hill Crest

Location

Talbot Co. Md.

18. Funeral director

J. J. Tracy, Jr. Son.

Address

Federalsburg Md.

19. 1/24/47

(Date rec'd by registrar)

19 47

M. H. Neeris

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State, Maryland County, Caroline

City or town, Federalsburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 1947 at 9 1/2 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 6 1947, to Jan. 24 1947

and that I last saw him alive on Jan. 24 1947

Immediate cause of death

Arteriosclerosis, generalized years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

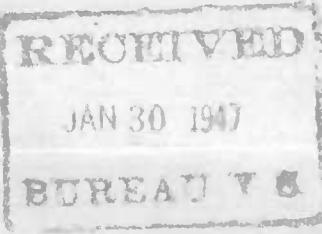
Means of injury Injured at work?

23. SIGNATURE

J. B. Cox, Jr.

M. D. or other

Address 300 S. Main St. Data signed 1-25-47



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

## CERTIFICATE OF DEATH

00896  
2900  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County Royal Oak Talbot Co.

City or town Easton, R.F.D. 4

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years

Hospital, Institution, or street address where death occurred.

How long in hospital or institution?

## 3. (a) FULL NAME

Walter Scott Wallach

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Married

B. (b) Name of husband or wife Carrie Wallach

7. Birth date of deceased (mo., day, yr.) 8. (c) If alive, give age 68 years 1876

8. AGE: Years 71 Months 4 Days If less than one day hrs. min.

9. Birthplace Talbot Co. (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business None

12. Name Mrs. Walter

13. Birthplace Talbot Co., Md.

14. Maiden name Harrietta Sherwood

15. Birthplace Talbot Co., Md.

16. Informant Mrs. Carrie Wallach

Address Royal Oak, Talbot Co., Md.

17. (Burial, cremation, or removal. Which?) Cemetery or crematory Royal Oak Date thereof Jan. 28, 1947 (month) (day) (year)

Cemetery or crematory Royal Oak

Location Royal Oak

18. Funeral director Leon W. Harvey

Address 310 South St. Easton, Md.

19. (Date rec'd by registrar) 1/22/47

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot

City or town Royal Oak

Street No. None R.F.D. 4

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21, 1947 19. at 7:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1, 1946 19. to Jan 21, 1947

and that I last saw him alive on Jan 20, 1947 19.

Immediate cause of death

Acute Uremia

Due to Anteriosclerosis

Arteriosclerosis General

Due to

Other conditions Hypertension

(Include pregnancy within 8 months of death)

Major findings of operations None

Date of op. None

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

St. Michaels, Md.

M. D. or other

Address Date signed 1.21.47

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JAN 25 1947

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